Exhibit 17-2

CLAIM STATUS REQUEST FORM

Provider Name :_____ **Provider # :**_____ **Contact :** _____

Please complete one request for each different provider ID. ****CRN and Claim Status Spaces for AHCCCS use only**

Recipient's name:	**Recipient's AHCCCS ID:**	**Dates of service:**	**Billed amount:**
****CRN:**	****Claim Status**		
Recipient's name:	**Recipient's AHCCCS ID:**	**Dates of service:**	**Billed amount:**
****CRN:**	****Claim Status**		
Recipient's name:	**Recipient's AHCCCS ID:**	**Dates of service:**	**Billed amount:**
****CRN:**	****Claim Status**		
Recipient's name:	**Recipient's AHCCCS ID:**	**Dates of service:**	**Billed amount:**
CRN:	**Claim Status**		
Recipient's name:	**Recipient's AHCCCS ID:**	**Dates of service:**	**Billed amount:**
****CRN:**	****Claim Status**		
Recipient's name:	**Recipient's AHCCCS ID:**	**Dates of service:**	**Billed amount:**
****CRN:**	****Claim Status**		
Recipient's name:	**Recipient's AHCCCS ID:**	**Dates of service:**	**Billed amount:**
****CRN:**	****Claim Status**		
Recipient's name:	**Recipient's AHCCCS ID:**	**Dates of service:**	**Billed amount:**

Completed By:_____ **Date completed:** _____ **Page** ____ **of** ____ **pages**